

CLEANSING THE MODERN HEART

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Every man's work, whether it be literature or music or pictures or architecture or anything else, is always a portrait of himself.—*Samuel Butler*

John Selden, a seventeenth-century English jurist and scholar, warned: "The reason of a thing is not to be inquired after, till you are sure the thing itself be so. We commonly are at, *what's the reason for it?* before we are sure of the thing" (cited in Keith Thomas, *Religion and the Decline of Magic*, p. 435).

We know what physics is: the study of matter and energy. What biology is: the study of living things. But what is psychoanalysis? Who speaks for psychoanalysis? We are familiar with Freud's many contradictory teachings and the diverse practices he engaged in, calling them all "psychoanalysis." We know that the term is used to refer to a method of diagnosing and treating mental illnesses, detecting mental illness in famous dead persons and in characters invented by poets and writers, explaining and influencing human behavior, and interpreting the "meaning" of works of art. Here are two current examples of what persons officially authorized to speak for psychoanalysis say about it.

In an essay titled, "Will the real psychoanalyst please stand up?" Richard Fox, president of the American Psychoanalytic Association in 2001, declares: "Psychoanalysis today is a far cry from what it was thirty to forty years ago.... We lobby in Washington.... We work with other groups such as the ACLU to further our goals" (*The American Psychoanalyst*, 2001, p. 27). Are these activities we ought to applaud? At present, the ACLU is engaged in formulating commitment laws, the better to justify incarcerating innocent Americans accused of mental illness. During World War II, it was engaged in supporting and justifying the incarceration of innocent Americans of Japanese ancestry (see Charles L. Markmann, 1965, and Thomas Szasz, *The Therapeutic State*, 1984, pp. 58-66).

The American Psychoanalytic Association, Fox proudly reports, no longer bars psychologists from membership: "We have extended our membership.... We have shed our medical orthodoxy and have become more egalitarian." This is not good enough. For its past policies, the American Psychoanalytic Association owes a collective apology to psychologists and homosexuals as well.

It would be a mistake to conclude that psychoanalysts have finally acknowledged that they do not treat diseases, because problems in living are not diseases and because listening-and-talking is not a medical procedure. On the contrary, analysts join psychiatrists in expanding the concepts of disease and treatment, assert that "psychotherapy changes the brain," and then use that claim to prove that they treat brain diseases. According to Glenn Gabbard, M.D., professor of psychiatry and director, Baylor Psychiatry Clinic and editor of the *International Journal of Psycho-Analysis*, "behavior therapy and drug therapy [are] affecting the same brain areas and in the same manner. ... Psychotherapy seems capable of favorably influencing the minds and bodies of persons with bodily diseases and perhaps is even capable of countering those diseases.... [It is important] to get scientific results that lend credibility to psychotherapy as a *real treatment*" (cited in Joan Arehart-Treichel, "Evidence is in: Psychotherapy changes the brain," *Psychiatric News* 2001, 36 (July 6), p. 33). Why is it important to claim that conversation with a psychoanalyst changes the client's—but presumably not the analyst's—brain? In order to qualify as loyal agents of the therapeutic state and be paid by the state for one's services to it.

Many years ago, I ceased to identify myself as a psychoanalyst. Why? Because I wanted to be faithful to my belief, which I have held ever since I knew anything about psychoanalysis, that *psychoanalysis is a moral, not a medical, activity*. Psychoanalysis has nothing whatsoever to do with illness or health, medicine or treatment, or any other idea that places “professional” listening and talking within the purview of the state’s licensing authority. Psychoanalysis is a particular kind of dialogue, one person providing a service, and another person receiving and paying for it. Accordingly, whenever possible, I refer to the recipient of the service as a client, not patient. I continue to use the word “therapist” because we lack an appropriate term to identify his role and function as secular, moral counselor. Because psychoanalysis is a moral enterprise, we must recognize and acknowledge that the analyst’s personal moral conduct shapes and is a relevant to our moral judgment of his professional activities and persona.

Few, if any, contemporary psychoanalysts share these views. Most analysts equate psychoanalysis with psychotherapy, consider psychotherapy to be a part of psychiatry, and believe that problems in living are diseases and that verbal and nonverbal communications are treatments.

My aim here, then, is to restate my faith in psychoanalysis as a secular-moral “cure of souls.” Psychoanalysis possesses a valuable moral core that has never been properly identified and is now virtually unrecognized: *It is, or ought to be, a wholly voluntary and reliably confidential human service, initiated and largely controlled by the client who pays for it.*

Rightly, Freud himself compared the psychoanalytic relationship with the Catholic confessional. Eager to establish the medical *bona fides* of his “therapy,” he was faced with the problem of the absence of somatic lesions or laboratory markers in his patients. He sought to overcome this problem by using “clinical material,” that is, “case histories.” (The term “clinical material” is an indispensable part of the incantatory magic of today’s practitioners of the “misbehavioral sciences” (Jacques Barzun’s term). As a result, he went so far as to explicitly reject the confidentiality of the psychoanalytic relationship. In “The history of the psycho-analytic movement” (1914), he wrote: “... I cannot allow that a psycho-analytic technique has any right to claim the protection of medical discretion” (SE, vol. 14, p. 64).

If psychoanalysis is to have a future—which, in our disease- and treatment-obsessed culture seems

doubtful—it lies in adopting that model to the needs of modern secular man, increasingly isolated from his fellow man and community, and betrayed by the therapeutic state in which he mistakenly seeks protection from the vicissitudes of life.

Freud’s Legacy

At the end of nineteenth century, Vienna was the crown jewel of Austria-Hungary, a flourishing, multi-ethnic, multi-lingual, multi-religious empire, with glittering sister capitals in Budapest and Prague. Although the country had a sizeable, intellectually vibrant middle class and its politics was increasingly liberal (in the classical sense), it was nevertheless still a highly traditional, Roman Catholic country, with German as its official language. Much like the United States prior to World War II, Austria-Hungary was also a country that was simultaneously anti-Semitic and hospitable toward Jews, especially if they were assimilated and patriotic. Freud’s career as a “Nervenarzt” must be clearly situated in this context.

Freud had many intellectual interests and was not keen about becoming a practicing physician. However, medicine was one of the (then) so-called “free professions,” open to Jews, and Freud decided to go medical school. He completed his medical studies but did not want to become a general (family) physician, like his later friend Josef Breuer. Accordingly, Freud studied neuropathology, spent a few months in Paris studying the work of Jean-Martin Charcot, and then started a private medical practice as a “Nervenarzt” (literally, “nerve doctor”), specializing in “nervous diseases.” It is important to keep in mind that these were nebulous terms used to identify a medical specialty that was neither neurology nor psychiatry. Why do I say this is important? Because it is here that the misrepresentation of problems of living as diseases and of interpersonal dialogue as treatment originates. The roots of this misconception—similar to the view that consecrated wine is, literally, blood—go very deep.

I use this Catholic metaphor here to re-emphasize the crucial importance of confidentiality in psychoanalysis, and its predecessor, catharsis. Actually, it was Josef Breuer who first used the confessional to explain the workings of his method of “mental treatment.” In *Studies on Hysteria* (1893-1895) (*The Standard Edition of the Complete Psychological Works of Sigmund Freud* [SE]), Breuer writes: “We meet the same urge [to verbally reveal secrets] as one of the basic factors of a major his-

torical institution—the Roman Catholic confessional” (vol. 2, p. 211). In a similar vein, Freud uses the model of the confessional in *The Question of Lay Analysis* (1926): “... our Impartial Person [says]. ‘You assume that every neurotic has something oppressing him, some secret. And by getting him to tell you about it you relieve his oppression and do him good. That, of course, is the principle of Confession, which the Catholic Church has used from time immemorial in order to make secure its *dominance over people’s minds*.’ We must reply: ‘Yes and no!’ ... In Confession the sinner tells what he knows; in analysis the neurotic has to tell more. Nor have we heard that Confession has ever developed enough power to get rid of actual *pathological symptoms*” (SE, vol. 20, p. 189, emphasis added).

Revealingly, Freud condemns the confessional in Catholic hands as a tool of religious domination, and praises it in psychoanalytic hands as a *medical* method of psychical liberation. Why medical? Because it frees the “patient” of *pathological symptoms*. To top it off, Freud advances the absurd claim that whereas the penitent in the confessional *tells only what he knows*, the client in analysis also *tells what he does not know*. The rest, as the saying goes, is history: the analyst knows the client better than the client knows himself. This is not the place to dilate on the consequences of this pernicious idea.

Despite the historical record, many people—mental health professionals, writers, book reviewers—often erroneously identify Freud as a psychiatrist (“Who was Sigmund Freud? Freud was a Psychiatrist and Psychologist,” 2002, <http://www.toppsychology.com/0050Sigmund%20Frueid/frued.htm>; <http://www.who2.com/sigmundfreud.html>; see also <http://www.breakpoint.org/Breakpoint/ChannelRoot/FeaturesGroup/BreakPointCommentaries/Grow+Up+or+Wake+Up.htm>). Freud was not, and could not have been, a psychiatrist. Why not? Because he was a Jew.

“Psychiatry” is a nineteenth-century term. What did it mean to be a psychiatrist in those days? It meant being an employee of the *state*: the psychiatrist oversaw the operation of a state insane asylum or worked as an asylum physician, assumed that mental diseases are brain diseases, and studied the brains of deceased mad persons. His patients were, *de facto*, prisoners. In 1925, William A. White, the famed director of St. Elizabeths Hospital in Washington, D.C.—founded in 1855 as

the Government Hospital for the Insane—stated: “The state hospital, as it stands today, is the very foundation of psychiatry” (cited in Sylvano Arieti, ed., *American Handbook of Psychiatry*, vol. 2, p. 686).

Many young and not so young psychiatrists are no longer aware that, from its birth in the eighteenth century until the beginning of the twentieth century, psychiatry (originally mad-doctoring) was synonymous with practice in the insane asylum and the state mental hospital; that all patients were committed patients; and that all psychiatry was actually or potentially *adversarial psychiatry*. To be sure, it was not seen or defined that way. How was that possible? By not questioning the transformation of the cooperative-contractual doctor-patient relationship typical of medical practice into the coercive-paternalistic guardian-ward relationship typical of psychiatric practice. *De jure*, the guardian represents the ward’s best interests. Similarly, by definition, the coercive-paternalistic psychiatrist represents the involuntary mental patient’s best interests. The practice of psychoanalysis created a new polarity, between the psychiatrist who controls and coerces, and the psychoanalyst who contracts and cooperates. In this political (not biological) sense, Freud “medicalized” psychoanalysis, that is, made its practice resemble medical, not psychiatric, practice.

Since being a psychiatrist meant being an employee of a *state* hospital, in Austria-Hungary Jewish doctors could not become psychiatrists. However, they could become “nerve doctors,” listen and talk to their clients, call what they do “psychoanalysis” (or “psychotherapy”), and sell their services to fee-paying customers. The psychoanalytic client, like the customer of any service supplied by entrepreneurs in the free market, sought out the analyst, went to his office, received a service, and paid a fee for it. The client was on top, the therapist on tap. This was—and still is, if indeed it exists except as a great rarity—a radical departure from the tradition of psychiatry. For centuries, the only patients of mad doctors, alienists, and psychiatrists were persons who did not want to be patients. Court-ordered mental hospitalization and treatment and the threat of such sanctions still form the core of the practice of psychiatry and the mental health professions generally.

It is instructive to compare the differences between the roles of the psychiatrist and the psychoanalyst in Freud’s Vienna with the differences, in medieval Christendom, between the roles of a

priest and a rabbi. The priest and psychiatrist had power: the priest could burn the heretic at the stake, the psychiatrist could imprison and torture the psychotic. In contrast, the rabbi and the psychoanalyst lacked power: the rabbi could engage only in voluntary relations with his fellow Jews, the psychoanalyst could “treat” only person who sought his services.

The psychoanalyst, unlike the psychiatrist, lacks power over his client: either because he is economically, socially, and politically weaker than the client, or because he voluntarily renounces the use of force, even if the state offers it to him. Thus, a weak and noncoercive psychoanalysis is antagonistic to and incompatible with a powerful and coercive psychiatry, just as peaceful Diaspora Judaism is antagonistic to and incompatible with militant Zionism (or as pacific Christianity or Islam are incompatible with their militant versions). I maintain that the single most fundamental characteristic of the psychoanalyst is his principled rejection to coerce his client, or indeed engage in any action for or against him outside the boundaries of their meetings.

Sadly, this posture did not issue from Freud’s moral outlook on human relations but was forced on him by his social circumstances. Freud did not reject medical power. He loved it. He never questioned the psychiatrist’s paradigmatic practices, involuntary mental hospitalization and the insanity defense. Like psychiatrists, Freud made medical diagnoses of his clients and maintained that they suffered from mental illnesses that were, at bottom, brain diseases. As a result, psychoanalysis became absorbed into psychiatry and medicine, especially in the United States after World War II.

Although the seeds of the practice of psychoanalysis were sown and germinated in the soil of the free market and depended on it for their survival, neither Freud nor the early analysts understood the market or supported its values. They only took advantage of it, like children taking advantage of wealthy parents. As soon as Freud got on his feet, economically and professionally, he embraced the style of the conquering hero, to which he always aspired. In 1900, he wrote to Wilhelm Fliess: “I am not at all a man of science, not an observer, not an experimenter, not a thinker. I am by temperament nothing but a conquistador” (p. 398). To Jung he announced that psychoanalysis must “conquer the whole field of mythology” (cited in Clark, p. 339). Freud’s self-image as a “conquistador” meshed with his ambition to conquer

psychiatry for psychoanalysis. The result was exactly the opposite: psychoanalysis became corrupted by psychiatry.

The Aims of Psychoanalysis

Like the core element of the classic concept of liberty, the core element of psychoanalysis is best stated as a negative, that is, as the absence of factors antagonistic to its aims and values. Political liberty is the absence of the coercions characteristic of the traditional relations between rulers and ruled. Similarly, psychoanalysis is the absence of the coercions characteristic of traditional relations between psychiatrists and mental patients. As Freud put it, “Analysis ... presupposes the consent of the person who is being analyzed...” (SE, vol. 14, p. 49). But Freud did not mean it. If he did, he would have opposed the “psychoanalysis” of children, involuntarily hospitalized mental patients, and dead persons, none of whom can consent to their existential assassination. In fact, he enthusiastically embraced and encouraged these practices.

Ironically, when I speak of my ideal model of psychoanalysis, I am simply taking seriously how Freud *sometimes* characterized it. I refer to Freud’s likening the relationship between analyst and client to the relationship between the vendor of an expensive personal service—say, a portrait painter—and a financially independent adult purchaser of his services. Neither party has power over the other; each is responsible for his side of an agreement. In his *Introductory Lectures on Psychoanalysis* (1915–1917), Freud framed this as the rule “of not taking on a patient for treatment unless he was *sui juris*, not dependent on anyone else in the essential relations of his life” (SE, vol. 16, p. 460, emphasis added). Thanks to the untiring efforts of enthusiasts for pharmacratic regulations—giving us Medicare, Medicaid, SSSI, HMOs, the DEA and drug regulations, the wars on depression and suicide, the duty to protect patients from themselves and others from the patients, and malpractice litigation—analysts and clients alike are effectively deprived of the very possibility of being *sui juris*. The therapeutic state compels everyone, without exception, to be dependent on the state in the essential medical and pharmacological aspects of his life.

Political liberty is contingent on the state’s respect for private property and its non-interference with acts between consenting adults. Psychoanalysis is contingent on the therapist’s respect for the client’s autonomy and his non-interference with

the client's life. This means that the therapist must limit his interaction with his client to listening and talking to him in the therapist's office and must abstain from meddling into the client's affairs and social life. Thus conceived, the psychoanalytic relationship was a new development in the history of mad-doctoring: it introduced into psychiatry and society a new form of "therapy for mental illness," one in which the expert eschewed coercing deviants and housing dependents and confined himself to conducting a particular kind of confidential dialogue. In the psychoanalytic situation, there is, in the medical and psychiatric sense, neither patient nor doctor, neither disease nor treatment. The dialogue between analyst and client is therapeutic in a metaphorical sense only. Purged of jargon, the psychoanalytic "procedure" consists only of listening and talking. So conceived, psychoanalysis undermines psychiatry as a medical specialty and system of social control.

Psychiatry did not acquire, and could not have acquired, any of the real substance of psychoanalysis. The two enterprises rested on different premises and entailed mutually incompatible practices. The marriage between the psychiatrist and the psychoanalyst was a misalliance from the start, each party disdaining and exploiting its partner. Psychiatry acquired the worst features of psychoanalysis—a preoccupation with sex and the past, an elastic vocabulary of stigmatizations, and a readiness for fabricating pseudo-explanations. Psychoanalysis acquired the worst features of psychiatry—coercion, mental hospitalization, and disloyalty to the client. Bereft of professional integrity, post-war American psychoanalysts enjoyed a brief period of irrational professional exuberance, followed by moral bankruptcy.

The Immorality of Psychoanalysis Today

What do I mean when I say that psychoanalysts, qua psychoanalysts, have become morally bankrupt? I mean that psychoanalysts do not mind their own business and instead mind the client's business. The analyst's business is to earn the client's confidence and trust by entering into a clear contract with him and by conscientiously abiding its terms. The Bill of Rights limits the powers of the state vis-à-vis the citizen, not the citizen's vis-à-vis the state. Similarly, the analytic contract limits the powers of the therapist vis-à-vis the client, not vice versa. The analyst's overriding obligation to the client is to protect his confidences. This obligation permits no exceptions. If the analyst morally

abhors what his client tells him, he has the option, like a defense attorney, of discontinuing the relationship. Under no circumstances does the psychoanalyst have the option to betray his client's confidence and use the information he has acquired, especially against what the client considers his own interest.

We often speak of empowering this or that politically weak or disfranchised individual or group. But people cannot be empowered directly. They can be empowered only indirectly, by taking power away from, or not giving power to, individuals or institutions that have actual or potential control over them. This is a lesson every parent must learn if he wants his child to become an independent adult. It is a lesson that all forms of psychiatrized psychotherapy violate, indeed indignantly reject—by assuming responsibility for the client's health, safety, and general well-being.

In Freud's time, as now, some people committed suicide. It did not occur to anyone in Vienna—least of all to lawyers or psychiatrists—that it was the analyst's duty to protect his client from himself. Nor would it have occurred to them that it was the analyst's duty to protect so-called third parties or the community from the potential violence of the client. Today, protecting the "mental patient" from himself—the anorexic from starving to death, the depressed from killing himself, the manic from spending his money—is regarded as one of the foremost duties of anyone categorized as practicing as a mental health professional, psychoanalysts included.

For half a century, I have argued and showed that a person professing to help a fellow human being in distress cannot be a double agent: he must choose between serving the interests of the client, as the client defines them; or serving the interests of the client's family or employer or insurance company, or the interests of his profession, religion, community, or the state, as they define them. As a rule, this view is either ignored or dismissed out of hand with the claim that a so-called mental patient's "true (mentally healthy) interests" cannot conflict with the interests of his "loved ones" or those of the community. If they do, it is because of his mental illness. The denial that the therapist deals with persons in conflict with others and that the process called "therapy" cannot—except accidentally or derivatively—help persons whose interests oppose or thwart those of the client characterizes virtually all modern therapies. For example, Constance T. Fischer, professor of psy-

chology at Duquesne University, introduces the 2002 special double issue of *The Humanistic Psychologist* with this sentence: "In this collection of articles, psychologists' approaches to assessment are *compassionate, caring, deeply respectful of the humanity of the clients, and courageous in efforts to be genuinely helpful to all parties*" (p. 1). This is self-congratulation concealing personal and professional self-aggrandizement. People whose lives are full of harmonious cooperation with others do not seek and are not subjected to mental health services.

Virtually everyone in and out of the therapy business now believes that, when the chips are down, the therapist must betray his client's confidences, in his "own best interest." Thus, in the present American legal and political context, there can be no secular cure of souls. For such a cure to be possible, it is necessary not only for the therapist to disarm himself of the power he possesses over the client, but also for custom and law to permit him to do, much as the priest in the confessional disarms himself and is permitted to do so. It is not priest's duty to protect the penitent from himself or the community from the penitent. He is not expected to protect the would-be suicide from killing himself, or the community from the acts of a would-be murderer, by denouncing them to the health or law enforcement authorities of the state. Indeed, he is expressly forbidden to so betray the person whose confession he hears.

Regrettably, psychoanalysts have shown no interest in what, some forty years ago, I called "the ethics of psychoanalysis," a term by which I meant, *inter alia*, the analyst's moral obligation to protect the client's confidences unhindered by conflicting obligations. Nor were psychoanalysts in a position to do so as long as they categorized their activity as belonging under the umbrella of health care and treatment. Had they been willing to acknowledge that all they do is listen and talk to the persons who seek their services, they might, like librarians, have been able to secure genuine legal recognition and protection of their role.

Librarians and booksellers do not pretend that they help their patrons improve their minds, their mental health, or their morals, or that they protect the public by preventing patrons from reading "dangerous" books. They recognize, and everyone recognizes, that their function is to manage libraries and sell book. Our right to freedom of the press and speech includes the right to privacy about what we read. Accordingly, librarians and booksellers have

no obligation to reveal what their patrons read, even if their reading material is deemed to pose a threat to the patrons or the public (see "Tattered Cover victorious in battle against search warrant," http://www.freeexpression.org/newswire/0408_2002.htm). Is the privacy of librarians and booksellers more deserving of legal protection than the privacy of psychoanalysts? Or is it that the former have valued and fought for their liberties, and the latter have neither valued nor fought for them?

Sad to say, an institutionalized system of psychoanalytic practice truly respectful of the client's autonomy and privacy has never existed. A few analysts may have aspired to such an ethic, but, as a group, psychoanalysts rejected it. The image of the analyst, a man sitting in a chair listening sympathetically to a woman lying on a couch, the analyst recoiling from the very idea of harming her, let alone imprisoning her, has no basis in reality. Many celebrated psychoanalysts—Harry Stack Sullivan, Erik Erikson, Karl Menninger, Frieda Fromm-Reichman, Thomas Freeman—"analyzed" involuntarily hospitalized "patients."

Actions speak louder than words, says the proverb. I would go further: when actions and words conflict, we must view the actions as the truth, and the words as lies. To dramatize the disjunction between words and deeds in psychoanalysis, I cite the practices of two famous psychoanalysts. First, here is a vignette of the work of Jacques Lacan. In 1945, when Picasso rejected his long-time mistress and model Dora Maar in favor of Francoise Gilot, Maar became depressed and annoyed Picasso. In a review in the *Times Literary Supplement* (2002, April 25), Marilyn McCully, writes: "A terrified Picasso, who abhorred illness, especially in women ... contacted Jacques Lacan, who had her admitted to a psychiatric clinic. Doujoune Ortiz [the Spanish author of a biography of Maar] goes into details about Lacan's machinations in looking after Maar and the horrific shock treatments that were prescribed as part of her therapy. She also makes the perceptive observation that Picasso's paintings of Maar as the weeping woman eerily anticipate the terrors she must have suffered in the moments before the shock treatments were administered" (p. 28). For another, similar version of this story, see Francoise Gilot and Carlton Lake Gilot, *A Life with Picasso: The Love Story of a Decade* (1964). New York: Discus Book, 1981: "He [Picasso] wanted to call Doctor Lacan, the psychoanalyst he *used* for most of his

medical problems, but didn't want to telephone in front of Dora, so he sent Sabartes [his chauffeur and all-purpose lackey] out to call, ... Lacan came at once. ... Professor Lacan kept Dora at the clinic for three weeks. At the end of that period he let her go home. He continued to treat her and she underwent *analysis* with him" (pp. 83-85, emphasis added).

The Scottish psychiatrist and psychoanalyst Ronald D. Laing's name is often bracketed with my name. Laing is thus often credited with the view that he opposed involuntary mental hospitalization and coercive psychiatric treatment. This is not true. In *The Divided Self*, Laing wrote: "*When I certify someone insane, I am not equivocating when I write that he is of unsound mind, may be dangerous to himself and others*, and requires care and attention in a mental hospital" (p. 27, emphasis added). In a 1979 review of three of my books in the *New Statesman*, Laing contemptuously dismissed my critique of the medical metaphor and my call for the abolition of psychiatric slavery. Even if all that I propose came to pass, he declared, "it would all be much the same." British psychoanalyst Anthony Stadlen did not let Laing's review stand uncorrected. He wrote: "Dr. Laing's new role as the 'perfectly decent' defender of psychiatry against Szasz's 'insulting and abusive fuss' calls for comment. Laing is saying unequivocally that 'it would all be much the same' to him whether involuntary psychiatry be retained or abolished. He is saying 'it would all be much the same' whether voluntary interventions, including his own, are intended as medical treatments for illness or as interpersonal counseling, ethical exploration, existential analysis. He implies quite clearly that he is one of 'the rest of us' who do use the medical metaphor" ("Dropping the medical metaphor," *New Statesman*, 1979, 17 August).

Although Laing co-invented the stupidly self-stigmatizing label, "antipsychiatry," he claimed he was not an antipsychiatrist. In the Introduction to his book, *The Dialectics of Liberation* (1968), David Cooper wrote: "The organizing group [of the 'Congress on the Dialectics of Liberation,' held in London in 1967] consisted of four psychiatrists who ... counter-label[ed] their discipline as anti-psychiatry. The four were Dr. R.D. Laing and me, also Dr. Joseph Berke and Dr. Leon Redler" (p. 7). Citing this passage, Adrian Laing, in a sympathetic biography of his father, comments: "Ronnie made two mistakes with David's introduction. First, he did not insist on reading it prior to pub-

lication. Ronnie did not consider himself an 'anti-psychiatrist'.... The damage, however, had been done. David managed to label Ronnie an anti-psychiatrist. Ronnie was furious at this move, but made a more serious mistake in not taking immediate and effective action to rectify his position" (Adrian C. Laing, *R. D. Laing: A Biography*. London: Peter Owen, 1994, p. 138).

But were these inactions "mistakes"? Or did they represent Laing's typical way of having his cake and eating it too, as Adrian aptly puts it? The evidence supports Adrian's interpretation. Laing's response to his oldest daughter Fiona's existential crisis is emblematic of his rejection of parental responsibility and lack of moral and intellectual integrity. In 1976, Fiona, then twenty-four years old, is rejected by her boyfriend: "She had 'cracked up,' and had been found weeping outside a church" near the family home. Committed to a local mental hospital, she is given ECT. Laing biographer John Clay writes: "He [Adrian] rang his father up and asked him 'in despair and anger' what he was going to do about it. Laing reassured him that he would visit Fiona and 'do everything in his power' to ensure that she was not given ECT, but when it came to the crunch, as Adrian Laing relates, all he could say was 'Well, Ruskin Place [the family home] or Gartnavel [the mental hospital]—what's the difference?' Such a scathing and deprecatory remark showed once again an avoidance of responsibility for his first family, indefensible since his line had been that the breakdown of children could be attributed to parents and families. Instead, Laing went into denial. When he gave an interview shortly afterwards in *New Society* he declared, 'I enjoy living in a family. I think the family is still the best thing that exists biologically as a natural thing'" (John Clay, *R D Laing: A Divided Self*. London: Hodder & Stoughton, 1966, p. 181).

There is worse. According to Adrian, Laing pitied himself, was a petty despot, and, when drunk, which was often, he was prone to violence. In one such episode, "No sooner had he got through the door ... than he attacked Karen [his daughter], then aged seventeen, and started to beat her unmercifully, until Paul and I intervened and restrained him. It was very frightening for all concerned" (Adrian Laing, p. 176). (Clancy Sigal's *Zone of the Interior* (1978), provides a vivid account of the moral squalor of Laing's life style and psychoanalytic practice.) An honest man is said to be as good as his word. By that measure, Laing was a very dishonest man indeed.

The Ethical Duty of Psychoanalysis

I have endeavored to re-articulate what I regard as the moral and political-economic core of, and the social conditions for, the psychoanalytic situation. They are: the inviolable privacy of the professional-client relationship; the client's willingness to assume responsibility for his behavior and pay for the service he receives; the analyst's willingness to eschew coercion justified by the legal-psychiatric principle of the "duty to protect" (the client from himself and the community from the client); the legal system's willingness to exempt the analyst from this principle (at present an integral part of the mental health professional's legal and social mandate); and the public's willingness to accept that a secure guarantee of privacy and confidentiality, similar to that granted the priest, as an indispensable condition for the proper conduct of psychoanalysis as a secular "cure of souls." These conditions are absent in the therapeutic state. The result is a tragic loss of liberty for client, "therapist," and society.

Psychoanalysis was conceived, raised, and over-indulged by medicine. Like many spoiled children, it chose not to reject its comforting but crippling patrimony, medical-therapeutic paternalism. As a result, it has failed to grow up and fulfill its potential, that is, adopt an explicitly anti-paternalist, libertarian stance as the proper posture towards adults who seek and are willing to pay for a private, confidential, secular, and trustworthy setting for looking into their hearts and souls and, perhaps, making themselves better persons.

The psychoanalyst's job is to help his client live his life as honestly and as responsibly, and hence as freely, as he can or wants to. This task has noth-

ing to do with illness and treatment in the sense in which these terms are used in medicine and psychiatry. However, it has a great deal to do with custom, law, economics, politics, and especially with religion as ethics. The term "psychoanalytic treatment" refers to, or ought to refer to, a particular kind of strictly confidential, private human relationship, similar to the Catholic confessional: it is a type of secular "cure of souls." The analyst's duty is to listen, speak, and fulfill his contract with the client, for example, by keeping the client's communications inviolably confidential and punctually collecting the fees due for his services.

The Christian believes that God does not hear the sinner. To be heard, the person must first cleanse his heart. That is a powerful metaphor. The wisdom it express is timeless. Where does it leave the atheist, the man who does not believe in and hence does not fear God? It leaves him fearing himself and having to cleanse his own heart.

The God-fearing man has it easier: he can more effortlessly persuade himself that God is listening to his prayers than the godless man can persuade himself that he is listening to himself. For the former, cleansing the heart can easily become an empty ritual. For the latter, it cannot. It is easier for a man to hide from God than from himself.

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